

HIGH FIELD OPEN MRI PATIENT QUESTIONNAIRE
MRI OF ANY EXTREMITY OR JOINT

Name _____ Date _____

What complaints or symptoms led you to seek medical help?

How long have you had these symptoms? _____

Have you had any recent trauma? If yes, please describe:

Do you have any history of fracture or surgery to the area of concern? Please be specific and give dates. _____

Do you have any history of cancer? Please be specific and give date of diagnosis.

Please note any other symptoms related to your exam and any results of previous studies.
